CHAPTER 1000 QUALITY ASSURANCE AND IMPROVEMENT

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BACKGROUND

In 2012, the West Virginia Bureau for Medical Services (BMS) Quality Unit was established under the Adult Medicaid Quality (AMQ) Grant awarded by the Centers for Medicare and Medicaid Services (CMS). The AMQ Grant was designed specifically to:

1. Develop a standardized reporting format for the CMS adult core set of measures
2. Establish an adult quality measurement program
3. Issue an annual report by the United States Secretary of Health and Human Services (HHS) on the reporting of adult Medicaid quality information
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures

While the AMQ Grant ends December 2016, the BMS Quality Unit will continue to provide quality assurance and improvement for WV Medicaid.

In 2015, the BMS Quality Unit assumed the responsibility for reporting of the Child Core Measures for the Medicaid population from the WV Children's Health Insurance Program (CHIP). This CMS core set included a range of children's quality measures encompassing both physical and mental health authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA required HHS to identify and publish a core measure set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs.

POLICY

1000.1 MISSION STATEMENT

Following the conclusion of the AMQ Grant, the West Virginia BMS Quality Unit will focus on improving the quality of healthcare for all Medicaid members, while being culturally-sensitive, cost effective and efficient. The Quality Unit's main objectives include data collection, data analysis, reporting the Core Measures to CMS, development of internal reporting processes, and obtaining accurate baseline data on the Adult Core Measures for quality improvement projects.

The BMS Quality Unit will explore the use of other national quality measures such as those from National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI), in order to carry forth the mission of BMS.

1000.2 QUALITY STRATEGY

The BMS Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to members in the Medicaid program:

- **Monitoring**: BMS monitors MCOs for compliance with its managed care quality standards.
- **Assessment**: BMS analyzes a variety of health care data to measure performance and identify focus areas for improvement, including indicators for specific diseases and populations.

- **Improvement**: BMS and its vendors, including the MCOs and the enrollment broker, implement interventions that target priority areas to maximize the benefit for Medicaid members.

The Quality Strategy outlines priorities for the Quality Unit. The priorities represent broad areas that will support the overarching aim for Medicaid to provide access to high quality health care for all members. BMS selected priorities that are flexible enough to accommodate changing conditions, such as an expansion in the benefits covered by MCOs, while providing a clear path to drive quality improvements.

- Make care safer by promoting the delivery of evidence-based care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment of diseases that burden Medicaid members

These priorities align with those identified by the National Quality Strategy, which was created under the Affordable Care Act and developed by the US Department of Health and Human Services. By coordinating its Quality Strategy with the National Quality Strategy, BMS increases the likelihood that its quality activities will coordinate with other national, state, or local health care improvement efforts. Where appropriate, BMS has selected performance measures and improvement goals to correspond with the priorities. These performance measures indicate areas within each priority that BMS will focus on improving. By aligning priorities, measures, and activities, and setting achievable goals, the Quality Strategy will drive quality improvement in the Medicaid program.

Additional information is available on Medicaid.gov located at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html

1000.3 CORE MEASURE REPORTING

The Affordable Care Act required the US Secretary of HHS to identify and publish a core set of health care quality measures for Medicaid-enrolled adults and children. Each year the CMS releases Technical Specifications for Adult and Child Core Measures. These measures are voluntarily reported by states. Implementation of the Adult and Child Core Set will help CMS and states move toward a national system for measurement, reporting, and quality improvement. The data collected from these measures will help West Virginia and CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive.

The Adult Core Set and Technical Specifications are available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html.

The Child Core Set and Technical Specifications available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html

As defined by the CMS Adult and Child Core Set Technical Specifications, some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a hospital discharge for a mental health condition. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year (i.e., calendar year 2014 data should be reported for FFY 2015).

Reporting of the core measures data is collected across all of the health care delivery systems used in West Virginia's Medicaid programs (i.e., Fee-for-Service (FFS) and Managed Care Organizations (MCO).

The Adult and Child Core Set have three possible data collection methods:

- **Administrative** - The administrative method uses transaction data (i.e., claims) or other administrative data sources to calculate the measure. This data can be used in cases in which the data is known to be complete, valid, and reliable. When administrative data is used, the entire eligible population is included in the denominator.
- **Hybrid** - The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. The denominator consists of a sample of the measure's eligible population. The hybrid method, when possible, should be used when administrative data and electronic health record (EHR) data are incomplete or may be of poor quality or the data elements for the measure are not captured in administrative data.
- **Survey** - The survey method uses data collected through a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to calculate the measure.

For measures that use the hybrid method, sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.

- For HEDIS measures that use the hybrid method, the sample size should be 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior years audited hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure.
- For the CAHPS survey, the sample size should be 1,350, plus an oversample based on the state's prior experience with survey response rates, to yield at least 411 completed surveys.

The BMS Quality Unit reports the Adult and Child Core Measures rates to CMS on an annual basis in the CMS MACPro system. If a measure is not collected, BMS must report to CMS why the measure was not collected (i.e., barriers, data not available).

1000.4 QUALITY IMPROVEMENT PROJECTS (QIPs) / PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

BMS contracts with an External Quality Review Organization (EQRO) to conduct annual, external independent reviews of the quality outcomes associated with timeliness of and access to services covered under each MCO Contract. The Bureau ensures through its contracts that each MCO has an ongoing quality assessment and performance improvement program for the services it furnishes to its members. Detailed MCO quality assessment and performance improvement requirements are contained in the MCO Contract, and Scope of Work. Please refer to *Chapter 1100, Mountain Health Trust Managed Care* of the BMS Provider Manual for additional information.

The BMS Quality Unit may implement quality improvement projects (QIPs) in addition to the MCO performance improvement projects (PIPs).

If CMS, in consultation with states and other stakeholders, specifies performance measures and topics for performance improvement projects to be required by states in their contracts with MCOs, the BMS Quality Unit will incorporate these performance measures and topics into the Quality Assurance and Performance Improvement (QAPI) program requirements.

1000.5 STAKEHOLDER ADVISORY BOARD

The BMS Quality Unit has a Stakeholder Advisory Board (SAB) comprised of BMS senior leadership, BMS Medical Director, BMS program areas, MCOs, EQRO vendor, other BMS contracted staff and Medicaid providers such as pharmacy, psychologist, obstetrics, gynecologist, pediatrics, and family medicine.

The BMS Quality Unit will ask SAB members for input on the collection, analysis, reporting, and use of the proposed measures to influence quality improvement for Medicaid members. SAB will also be asked to review proposed activities/interventions and provide input in the development of quality improvement projects.

The BMS Quality Unit will meet with the SAB on a bi-annual basis to share findings from reported measures, review potential measures, review findings from QIPs, and discuss potential QIPs.

1000.6 COLLABORATION ACTIVITIES

Collaboration is a key focus in developing innovative and creative solutions to meet the goals of quality assurance and improvement. The BMS Quality Unit collaborates on quality improvement initiatives with various entities some of which are listed below:

- Centers for Medicare and Medicaid Services (CMS)
- Medicaid Managed Care Organizations (MCO)
- EQRO Vendor
- Providers
- WV Medicaid Non-Emergency Medical Transportation Broker
- Other State Agencies and Vendors

The BMS Quality Unit collaboration activities include but are not limited to:

- Development of Quality Strategy
- Collection and reporting of Adult and Child Core Measures

- Analysis of core measure data:
    - Identification of priorities for quality improvement activities
    - Identification of quality improvement projects
    - Identification of interventions for quality improvement projects
- Implementation of quality improvement projects and activities

Collaboration between all stakeholders is encouraged and supported through effective communication. This ensures that Medicaid's behavioral and medical clinical programs, care coordination, and case management serve members appropriately and effectively.

1000.7 MEMBER AND PROVIDER OUTREACH

The BMS Quality Unit may provide outreach to members and providers as appropriate based on findings within the data from the measures, claims data reviews, inquiries from other providers, inquiries from members, suggestions from the MCOs and/or the EQRO vendor, and initiatives from BMS senior management.

For example, outreach to members such as childhood immunization reminders, flu vaccination outreach, importance of follow up appointments, and disease management may be utilized.

The BMS Quality Unit maintains a Quality Corner within the BMS Quarterly Provider Newsletter which provides information on the quality measurement data, quality improvement projects, or other quality activities.

1000.8 QUALITY MEASURE REPORTING

On an annual basis, the BMS Quality Unit will provide BMS senior management with results of NCQA quality measures consistent with reporting by the Medicaid MCOs for comparison of the quality of healthcare for Fee for Service population and the MCO population. The BMS Quality Unit may also provide reporting on other nationally accepted, statistically valid measures as appropriate.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

REFERENCES

Additional information is available on Medicaid.gov located at:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
New Chapter	Quality Assurance and Improvement		TBD